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THESIS

THE RELEVANCE OF EMPOWERMENT
TO THE NAVY MEDICINE EXECUTIVE
MANAGEMENT EDUCATION PROGRAM

by

Brian M. Farmer

December, 1993

Principal Advisor:
Associate Advisor:

Kenneth W. Thomas
Kenneth L. Orloff

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The Relevance of Empowerment to the Navy Medicine Executive Management Education Program

by

Brian M. Farmer

Lieutenant, Medical Service Corps, United States Naval Reserve
B.A., Madonna University, 1982

**Submitted in partial fulfillment
of the requirements for the degree of**

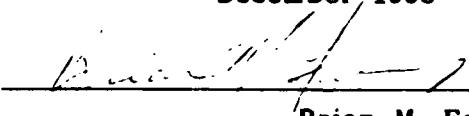
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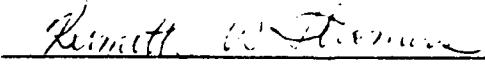
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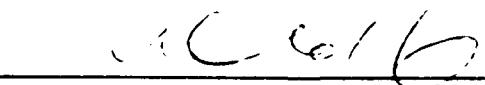
Author:


Brian M. Farmer

Approved by:


Kenneth W. Thomas

Kenneth W. Thomas, Thesis Principal Advisor


Kenneth L. Orloff, Thesis Associate Advisor


David R. Whipple, Chairman
Department of Administrative Sciences

ABSTRACT

The purpose of this thesis is to explore the need for empowerment education for the Navy Medicine Executive Management Education Program. Data from the NPS/BUMED Survey (1992), the Healthcare Forum Survey (1992), and other sources are analyzed to determine the perceived needs and benefits of empowerment training. Existing Navy Programs as well as a private sector program are reviewed in order to determine whether these programs could fill this need.

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I. INTRODUCTION

A. BACKGROUND

Recognizing a need for greater management skills in military medicine executives, Congress directed the Department of Defense to ensure prospective military medical treatment facility commanders possessed necessary professional administrative skills. The Navy's Bureau of Medicine and Surgery (BUMED) turned to the Naval Postgraduate School (NPS) to develop ideas on how best to meet the Congressional directive. BUMED executed the necessary funding for NPS to develop their proposed Executive Management Education (EME) Program. The EME, which is presently in its initial test and evaluation phase, is a set of independent modules of instruction on executive management areas such as finance, communication, and empowerment. The EME is envisioned to be an ongoing/evolving set of modules that will continue to improve as more feedback is given by the executives who participate in the classes. Initial positive reaction from BUMED and Congress to the NPS-developed EME has generated interest from leaders in both Air Force and Army Medicine.

This thesis addresses the relevance of empowerment to the curriculum of the EME program. A series of best-selling management books have urged managers at all levels to empower

employees under their supervision in order to increase performance and innovation, improve morale, or even to smooth transitions within the company (e.g., Block, 1987; Byham, 1992; Manz, 1991). Still, there is no agreed upon, precise definition of empowerment. This thesis will use the Empowerment Profile developed by Thomas and Tymon (1993) to help define empowerment and its sources. In doing so, it will build upon the previous thesis work of Lieutenant Commander Marybeth Newton, United States Navy (1993) and Captain Steven M. Christy, United States Army (1992). LCDR Newton prepared an in-depth case study on effective leadership through empowerment in Navy Medicine, while CAPT Christy explored the link between intrinsic motivation and Deming's view of total quality management.

With a clearer definition of empowerment, this thesis will then examine the need for, and recommended content of, empowerment modules for the EME Program.

B. THESIS OBJECTIVES/RESEARCH QUESTIONS

The two primary questions addressed in this thesis involve the need for empowerment training in the EME Program and what content should be offered. This thesis also addresses a number of subsidiary questions. The first set addresses the nature of empowerment and evidence of its potential importance to Navy Medicine. The second set addresses what empowerment

training is presently being delivered in Navy Medicine and elsewhere.

C. ORGANIZATION OF THE THESIS

Chapter II develops a deeper understanding of empowerment, focusing on its motivational content, and the interventions that produce it, drawing upon the work of Thomas and Tymon (1993).

Chapter III explores available evidence to determine how important empowerment is to Navy Medicine. Recent survey results will be analyzed. There will also be a brief review of empowerment's role in Total Quality Leadership (TQL) and a review of two case studies involving empowerment at Naval Medical Treatment Facilities.

Chapter IV identifies what empowerment education is now being delivered in Navy Medicine and elsewhere. NAVLEAD, Navy TQL training, and an existing private sector program will be reviewed.

Chapter V will determine whether there is a gap in empowerment education in Navy Medicine based upon evidence considered in Chapters III and IV.

Chapter VI provides a brief summary of findings and makes recommendations for the EME program.

II. WHAT IS EMPOWERMENT?

This Chapter provides a fairly comprehensive map or model of empowerment and its components, based largely on the work of Thomas and Tymon (1993). For a more comprehensive evaluation of this model, and its relationship to other models, see Hatton (1993, in progress). Hatton concludes that the model is unique in its breadth, including both a general theory of what motivates empowered behavior and a more specific set of management actions (interventions) which can be taken to empower workers.

A. THE VARIETY OF DEFINITIONS

There is no single definition of empowerment (Thomas and Velthouse, 1990). For example, Merriam Webster's Dictionary (1986) defines the verb, "empower," as "to authorize or delegate or give legal power to someone," while the Oxford English Dictionary (1986) defines it as "to enable." Management scholars also have a similar wide range of views when it comes to defining empowerment. W. Burke says, "To empower, implies the granting of power - delegation of authority" (Burke, 1986). In contrast, Conger and Kanungo (1988) view empowerment as a motivational concept based on workers' sense of self-efficacy.

Conger and Kanungo help us understand the fundamental confusion by noting that empowerment has been defined both as (1) a set of management interventions and (2) the motivational effects of these interventions on workers. We will use this distinction here to make sense of empowerment. First, we shall address the nature of the motivational elements of empowerment. Then, working backwards, we shall identify empowerment interventions which produce these motivational elements.

B. THE MOTIVATIONAL CONTENT OF EMPOWERMENT: INTRINSIC MOTIVATION

Following Conger and Kanungo, K.W. Thomas and B.A. Velthouse attempted to pin down the nature of the motivational aspect of empowerment. In their 1990 article, "Cognitive Elements of Empowerment: An 'Interpretive' Model of Intrinsic Task Motivation," they defined empowerment in terms of intrinsic task motivation.

Although there are several models of intrinsic motivation, there has been no agreement on a precise definition (Lee, 1987). However, two common themes have emerged from the various definitions of intrinsic motivation (Christy, 1992). The first theme is "the individual's perception of control, of both environmental events and his own behavior" (Broedling, 1977). If the individual's motivation comes from himself as

an origin of his actions, he will consider himself to be intrinsically motivated (Notz, 1975; Christy, 1992).

The second common theme revolves around the individual obtaining rewards directly from the task itself. Lepper (cited in Lee, 1980) defined intrinsic motivation as "a process of engaging in an activity for its own sake." Tymon said that intrinsic motivation "involves positively valued experiences associated directly with task behavior" (Tymon, 1988). These rewards or positively valued experiences are often described as positive feelings (Christy, 1992).

This thesis will use the Thomas and Velthouse definition:

Intrinsic motivation involves positively valued experiences that the individual derives directly from the task (Thomas and Velthouse, 1990).

This working definition includes both themes, the notion that intrinsic motivation comes from the self and involves rewards associated with the task itself (Christy, 1992). In contrast, extrinsic motivation is based on rewards/punishments which are external to the task and are controlled by others.

Why is empowerment defined in terms of intrinsic motivation? Thomas and Velthouse (1990) assert that the growing emphasis on empowerment reflects a widespread shift in philosophies of management. The traditional, bureaucratic view of management emphasized establishment of work procedures by managers and the use of extrinsic rewards controlled by managers to ensure that workers comply with these procedures. In the newer, emerging view, by contrast, the emphasis is upon

making sure that workers are psychologically committed to the task purpose so that they can exercise self-control and innovate in the service of that purpose. In order for workers to behave consistently in this fashion, in turn, they must care about the task and derive psychological rewards from doing it well.

There is a growing consensus among contemporary management writers that organizations require a shift in emphasis from extrinsic motivation to intrinsic motivation. In his 1985 article, "From Control to Commitment in the Workplace," Walton speaks of a transformation in work-force strategy from the controlling practices of management to eliciting commitment on the part of workers through the use of self-supervising work teams, cross-training, and continued employment assurances. In the healthcare field, Dveirin and Adams (1993) state that:

Work structured on the basis of compliance rather than empowerment forces people to shrink to fit their jobs. The 'rules' too easily take the place of the mature judgment that people would otherwise exercise naturally in response to changing circumstances.

Likewise, Senge (1992) concludes that Deming's (1986) philosophy of continuous improvement is based squarely on intrinsic motivation and goes on to conclude that intrinsic motivation is a primary requirement for both worker learning and quality:

A corporate commitment to quality that is not based on intrinsic motivation is a house built on sand... From the intrinsic perspective, people's innate curiosity and desire to experiment, if unleashed creates an engine for improvement that can never be matched by external rewards.

Manz (1991) also concludes that intrinsic motivation is a key requirement for self-management. A very readable account of how intrinsic rewards ("ZAPPS") energize empowered workers can be found in the book, ZAPP! The Lightning of Empowerment by W.C. Byham (1992).

C. THE ELEMENTS OF INTRINSIC MOTIVATION

In their model of empowerment, Thomas and Velthouse (1990) view intrinsic motivation as involving positively-valued experiences (rewards) that individuals derive directly from a task, or "those generic cognitions by an individual, pertaining directly to the task, that produce motivation and satisfaction" (Thomas and Velthouse, 1990).

Thomas and Velthouse identified four "task assessments," judgments which individuals make about their work tasks that provide these rewards. These variables were derived from a literature review of themes involved in empowerment: impact, competence, meaningfulness, and choice. Spreitzer (1992), in an independent review, provided a very similar set of themes derived from the empowerment literature - four themes of impact, competence, meaning, and self-determination. The fact that both sets of researchers arrived independently at similar conclusions suggests that we can view these elements with some confidence.

The Thomas-Velthouse model was tested by Lee (1987) and Sutz (1991) and further refined by Thomas and Tymon (1993).

Thomas and Tymon operationalized and tested central features of the Thomas and Velthouse model, verifying that the four task assessments are distinct concepts for managers and showing a strong relationship between task assessments in the model and the expected outcome measure of job satisfaction (Christy, 1992).

When Thomas and Tymon first analyzed the results of the questionnaire used to test central features of their model, they found that responses regarding progress and impact tended to band together in the same factor which they called "impact." In later studies, the sense of impact (making a difference) appeared to be an aspect of task meaningfulness (Christy, 1992). As a result, they dropped impact as a separate task assessment and adopted the term "progress" as more accurately capturing the fourth task assessment.

In their Empowerment Inventory, Thomas and Tymon have continued to develop the notion of the four task assessments as rewards and have interpreted them as "feelings of empowerment" as shown in Figure 1.

	Sense of Opportunity	Sense of Accomplishment
Task Activities	Choice	Competence
Task Purpose	Meaningfulness	Progress

Figure 1: The Four Feelings of Empowerment (Source: K.W. Thomas and W.G. Tymon, Jr., Empowerment Inventory, Tuxedo, New York: XICOM, 1993).

As shown by the two rows of the grid, the two aspects of a task are the task activities an individual performs and the task purpose he/she tries to achieve. Task activities provide a vehicle for feelings of choice and competence, while the task purpose provides a vehicle for feelings of meaningfulness and progress. The two major types of feelings an individual has about a task involve a sense of opportunity, which include the task assessments choice and meaningfulness, and a sense of accomplishment, comprising the task assessments of competence and progress (Christy, 1992). Thomas and Tymon (1993) describe the four task assessments as follows:

CHOICE is the opportunity you feel to select task activities that make sense to you and to perform them in ways that seem appropriate. The feeling of choice is the feeling of being free to choose - of being able to use your own judgment and act out of your own understanding of the task.

COMPETENCE is the accomplishment you feel in skillfully performing task activities you have chosen. The feeling of competence involves the sense that you are doing good, quality work on a task.

MEANINGFULNESS is the opportunity you feel to pursue a worthy task purpose. The feeling of meaningfulness is the feeling that you are on a path that is worth your time and energy - that you are on a valuable mission, that your purpose matters in the larger scheme of things.

PROGRESS is the accomplishment you feel in achieving the task purpose. The feeling of progress involves the sense that the task is moving forward, that your activities are really accomplishing something.

When individuals derive these feelings from their work tasks, they are said to be "empowered."

D. EMPOWERMENT INTERVENTIONS

Figure 2 portrays the logic of what has been discussed so far. Empowerment, the left circle, consists of both empowering interventions and their motivational effects upon workers. Motivation, the right circle, consists of non-empowerment motivation in workers. We have concluded that the motivational content of empowerment (the area of overlap between the circles) is intrinsic task motivation rather than extrinsic task motivation. We have further broken down intrinsic task motivation into four elements - choice, competence, meaningfulness, and progress. Working backwards, we shall now use those four elements as a systematic means of identifying and categorizing empowerment interventions. Basically, we will assume that an empowering intervention is any action by a manager that has an empowering motivational effect upon a worker. Therefore, an empowering intervention

is any action that increases one or more of the four task assessments.

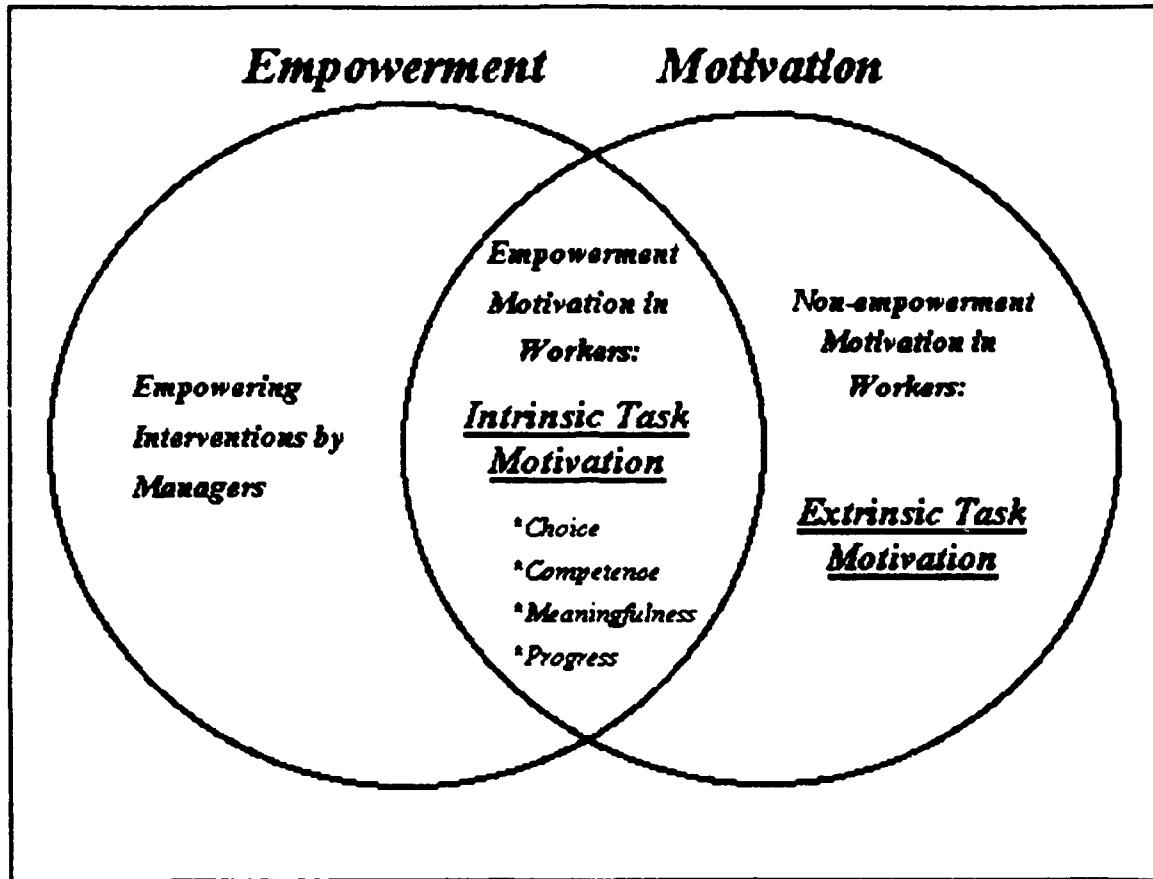


Figure 2: Breakdown of empowerment into managerial interventions and intrinsic task motivation in workers.

Thomas and Tymon (1993) offer their synthesis of the diverse empowerment intervention strategies offered by different writers. They identify a number of "building block" variables for empowerment which contribute to each of the four feelings of empowerment. In turn, they propose actions that can be taken by a worker's team members, including the team leader/supervisor. Those actions and building block variables

are shown below in Table One (Thomas and Tymon, 1993; used by permission).

TABLE 1. BUILDING BLOCK VARIABLES AND INTERVENTIONS WHICH CONTRIBUTE TO THE FEELINGS OF EMPOWERMENT

FEELING	BUILDING BLOCK	INTERVENTION
Choice	Authority	Giving members the right to make decisions on matters affecting their task, including the spending of money and other resources
	Trust	Trusting members' judgment; giving them space to exercise it
	Security	Supporting members' experimentation; no blame or punishment for honest mistakes
	Purpose	Deciding upon a clear team objective or direction to guide decision making
	Information	Sharing with members all the information they need to make informed decisions
Competence	Models	Providing models of how to perform tasks through training, role modeling, mentoring, and shared learnings
	Positive Feedback	Giving members feedback that is more "appreciative" (positive) than "deficiency-focused" (negative). Helping them build on what they do well rather than highlighting mistakes and shortcomings
	Skill Recognition	Giving members credit for what is going well; attributing it to skill (rather than to luck, others, or an easy task)
	Growth Opportunities	Allowing members to "stretch" by gradually taking on more demanding or challenging tasks
	Non-Comparative Standards	Not putting members in competition for credit, so that recognizing one member's competence is not a threat to others
Meaningfulness	Non-Cynical Climate	Providing a non-cynical climate that encourages idealism and caring
	Clear Values	Developing a shared value system for the team that identifies what is important
	An Exciting Vision	Developing an exciting vision of the future that the team wants to create, and how it would add value to the world
	Relevant Task Purposes	Adopting task purposes that are clearly related to the vision; protecting members from busywork tasks that have little value
	Whole Tasks	When possible, giving members tasks that are whole projects or at least major, identifiable portions of a project

TABLE 1 (continued)

FEELING	BUILDING BLOCK	INTERVENTION
Progress	Collaboration	Collaborating with team members when coordination and support are needed
	Milestones	On longer tasks, providing a clear picture of key events (milestones) that will occur in achieving the task purpose
	Celebrations	Drawing attention to members' task progress by celebrating important milestones
	Customer Appreciation	Providing feedback from customer(s) on their satisfaction (a measure of task success)
	Continuous Improvement	On recurring tasks, using customer feedback and other information to help members continuously improve their task performance

(Source: K.W. Thomas and W.G. Tymon, Jr., Empowerment Inventory, Tuxedo, NY: Xicom, 1993)

E. SUMMARY

Building upon a model of empowerment developed by Thomas and Tymon (1993), this Chapter has provided a fairly comprehensive model or map of empowerment and its components. Empowerment can be divided up into its motivational content, intrinsic motivation, and the interventions that influence it. In turn, intrinsic motivation is based on four "feelings of empowerment": choice, competence, meaningfulness, and progress. A number of specific interventions are identified which are believed to produce each of these feelings.

III. WHAT EVIDENCE DO WE HAVE THAT EMPOWERMENT IS IMPORTANT TO NAVY MEDICINE?

This Chapter examines available evidence which bears on the importance of empowerment skills to Navy Medicine. Four sets of evidence are considered: (a) survey data from Navy Medicine executives; (b) survey data from leaders in the larger healthcare industry; (c) an analysis of the views of W. Edwards Deming; and (d) case studies of empowering leadership in Navy Medicine.

A. THE NPS/BUMED SURVEY

As a means of identifying the needed content of the EME Program in Navy Medicine, members of the Department of Administrative Sciences at the Naval Postgraduate School conducted an extensive set of interviews, followed by the administration of a structured questionnaire. Resultant data provides the most direct evidence of the importance of various skill areas/competencies as seen by Navy Medicine executives themselves. A description of the survey and its findings can be found in Crawford, Roberts, Orloff, 1993.

1. Methodology

Semi-structured interviews were conducted with Navy Medicine executives at various management levels in 1992. The interviewers then listed skill/competency areas that

interviewees cited as being important for effective Commanding Officers and Executive Officers, and counted the number of interviewees who mentioned each skill area. The most frequently cited skill/competency areas (sixty in all) were then identified and incorporated into a survey questionnaire. This questionnaire was distributed in November, 1992, to 720 Navy Medicine executives, including all Commanding Officers and Executive Officers, Directors, and those screened for CO/XO billets.

There was a 66% response rate to the questionnaire, totalling 476 participants. The breakdown of respondents by Corps was 32% Medical Corps (154), 34% Medical Service Corps (164), 20% Dental Corps (97), and 11% Nurse Corps (50) (Crawford, Roberts, Orloff, 1993). For each skill area on the questionnaire, respondents were asked to rate (a) how important that skill area was to the effectiveness of an executive at their level in Navy Medicine, and (b) their own current skill level. Respondents were asked to assign a numeric value from 0 to 10 to each rating, with 0 meaning no skill possessed/required and 10 meaning a very high level of skill is possessed/required.

One of the questions in the survey, #35, asks specifically about empowerment. However, several other questions get at competency areas which are strongly related to empowerment. These questions are listed in Table 2,

together with their relationship to empowerment, using the model of empowerment described in Chapter II.

TABLE 2. EMPOWERMENT-RELATED QUESTIONS ON EME QUESTIONNAIRE

Question	Relationship to Empowerment
14. Deciding the extent to which others should be included in decision making.	Building block for Choice
34. Developing and communicating a vision for the command.	Building block for Meaningfulness
35. Empowering individuals and work groups.	Empowerment
37. Building trust.	Building block for Choice
38. Managing change.	Outcome of empowerment
39. Managing conflict.	Building block for Progress
40. Building teamwork.	Building block for Progress
41. Developing a positive organizational climate/culture.	Building block for Meaningfulness
42. Motivating people.	Empowerment is a type of motivation (intrinsic motivation)
44. Developing subordinates: coaching, teaching, mentoring.	Building block for Competence
46. Promoting innovation and risk taking behavior.	Outcome of empowerment
54. Giving positive and negative feedback.	Building block for Competence and Progress
59. Fostering a climate of open communication.	Building block for Choice and Progress

2. Results

For this analysis, answers to questions were classified as high (ratings of 8 to 10), medium (4 to 7), or low (0 to 3). Table 3, below, shows the percent of respondents who rated each empowerment-related question as high, medium, or low in terms of its requirement as a skill/competency.

TABLE 3. RESPONDENTS' PERCEPTION OF IMPORTANCE OF EMPOWERMENT-RELATED SKILLS

QUESTION NUMBER	SKILL AREA/COMPETENCY	LOW	MED.	HIGH
14	Participation	2	14	84
34	Vision	2	12	86
35	Empowerment	1	10	89
37	Trust	0	7	93
38	Managing Change	0	6	94
39	Conflict Resolution	0	8	92
40	Teamwork	1	6	93
41	Culture	1	5	94
42	Motivation	1	5	94
44	Subordinates	1	9	90
46	Innovation	1	14	85
54	Feedback	1	6	93
59	Open Communications	0	5	95

As shown in the table (Question 35), 89% of respondents view empowerment skills as high in requirement for CO/XO's. The same pattern shows up on the other skill or competency areas related to empowerment. Appendix A shows further

breakdowns of these results, by respondent's position, rank, and Corps affiliation. Although there are some differences among categories of respondents, the patterns remain remarkably similar, indicating that all categories of respondents tend to see these empowerment-related competencies as highly important.

B. THE HEALTHCARE FORUM SURVEY

The second piece of evidence bearing on the importance of empowerment in Navy Medicine involves a national study of the larger healthcare industry conducted by the Healthcare Forum (1992). The study investigated the gap between the leadership competencies and values practiced today and those necessary to lead 21st Century healthcare organizations.

The Healthcare Forum is a resource organization in management, education, and research in the healthcare industry. It attempts to be impartial in the sense that "innovation is the only special interest it champions" (Healthcare Forum, 1992). Its membership is comprised of healthcare executives from all 50 states and 14 foreign countries. The Leadership Center is the Forum's applied research arm which conducted the Healthcare Forum Study in 1992.

1. Methodology

A national survey was sent to over 2,500 healthcare opinion leaders, including executives, physicians, insurers,

suppliers, consultants, and academics. Survey results reflect the responses of approximately 400 respondents. They were asked to rate 36 defined leadership values and competencies for current prevalence (1991) and in the year 2001.

2. Results

Survey respondents indicated that a significant gap exists between current practices and those practices necessary to meet the demands of the future. These leaders perceive that transformational values and competencies, only lightly practiced today will be of critical importance by the year 2001 (Healthcare Forum, 1992).

Roughly 1/3 of the skills seen as vital to success in the 21st Century were identified as aspects of empowerment. These include viewing empowerment as an area of the "new paradigm," continuous quality improvement (CQI), team learning, a "we" approach, cross-functional structures, and fostering enrollment.

Overall, this study of survey results of 400 healthcare leaders sees empowerment not as an option but as a requirement if the healthcare system's troubles are to be overcome (Healthcare Forum, 1992).

C. TQL AND EMPOWERMENT

The third piece of evidence concerning the value of empowerment to Navy Medicine involves analysis of the role of empowerment in Total Quality Leadership (TQL) - the philosophy

of management officially adopted by the Department of the Navy.

In 1989, the Department of the Navy (DON) began the transformation to TQL. Through the effective use of TQL principles based on the philosophy of Dr. W. Edwards Deming, the Navy will strive to meet the challenge of becoming a "smaller, leaner, more efficient" organization (Newton, 1993). The leadership in Navy Medicine have embraced the concepts of TQL as defined:

The Department of the Navy (DON) approach to quality improvement is called Total Quality Leadership or TQL. DON leaders examined various approaches and concluded from their studies that Deming's philosophy and methods best suited the unique requirements of the organization. Deming emphasizes the leadership responsibility and offers a systems approach to managing work and leading people. In the view of the department, his approach is the most comprehensive - driven from the top, focused on the user, with decisions based on hard data (Suarez, 1992).

Deming's approach to quality relates to higher productivity through process improvement. This improvement leads to reduced costs. He emphasizes the importance of giving authority to the line worker (delegation) to make recommendations for improvement. The Deming philosophy also emphasizes teamwork and cooperation. In the empowerment model discussed in Chapter II, these same elements are prevalent. Additional analysis on empowerment and TQL can be obtained through the Christy thesis (1992), the Senge article (1992), and the Deming Library videos.

In a previous thesis, Christy (1992) analyzed in detail the relationship between Deming's philosophy and the core of the Thomas/Tymon model of empowerment - intrinsic motivation and the four feelings of empowerment. Christy concluded that intrinsic motivation was a key element of Deming's approach to total quality.

This same conclusion was reached by Senge (1992), who described Deming's view as follows: "People are born with intrinsic motivation, self-esteem, dignity, curiosity to learn, joy in learning" (Senge, 1992, quoting Deming, 1986).

Christy also concluded that Deming has been fairly imprecise or general in his description of what intrinsic motivation consists of. Deming (1986) has used the term "pride of workmanship" to get at the general feeling of intrinsic motivation in workers without breaking it down to its component feelings. In a detailed analysis of his writings, however, Christy found that there were themes in his work corresponding to the need for workers to experience each of the four feelings in the Thomas/Tymon model - choice, competence, meaningfulness, and progress. Thus, Christy concluded that empowerment is central to Total Quality Leadership and that the model helps to make explicit what has been implicit in Deming's philosophy about the motivational foundations of worker behavior in Total Quality.

D. CASE STUDIES OF EMPOWERING LEADERSHIP IN NAVAL MEDICINE

The fourth piece of evidence concerning the importance of empowerment to Navy Medicine involves two case studies of empowering leadership in Navy medical treatment facilities (hospitals). Both of these case studies demonstrate that empowering leadership styles can be highly successful within Navy Medicine.

1. Captain William R. Rowley, MC, USN

The first case study, by LCDR Mary Beth Newton (1993), involved an analysis of the management philosophy and effectiveness of Captain William R. Rowley, MC, USN, who was then Commanding Officer (CO) of Naval Hospital Camp Pendleton. Captain Rowley was selected for study because he was identified as having a reputation in his community as an innovator and advocate for empowerment. Newton conducted approximately 6 hours of interviews with Captain Rowley, conducted interviews with 17 other people at various levels in the command, and analyzed various documents produced within the Command.

Using the Thomas/Tymon model of empowerment as one of her theoretical foundations, Newton showed that Captain Rowley's management philosophy was consistent with the model. That is, elements of his philosophy seemed equivalent to encouraging the four feelings of choice, competence, meaningfulness, and progress. Her interviews with Captain

Rowley's subordinates also consistently showed that they reported higher levels of these feelings as a consequence of his leadership. Thus, Newton concluded that Captain Rowley was in fact an empowering CO.

Newton's findings also indicated that Captain Rowley was highly effective as CO. In addition to winning the confidence of his subordinates, Newton documented Rowley's effectiveness at instituting TQL within the Command and the accomplishment of a large number of special projects. Moreover, Newton concluded that Rowley's management style was consistent with the principles of sound financial control and identified savings to DON of over \$400,000 that could be directly attributed to his management.

2. Naval Regional Medical Center San Diego

The second case study by Capt. Jay Hatton, USMC (Hatton, in progress) is being completed as this is being written. As a part of a thesis on the role of empowerment in TQL, Hatton identified Naval Regional Medical Center San Diego (NRMCS) as the Navy medical treatment facility with the reputation of being the leader in the implementation of TQL. Based upon interviews with 20 managers at NRMCS, Hatton found that empowerment was seen as central to the success of TQL at the Command. Hatton goes on to identify management changes (or interventions) which seem to account for much of the effectiveness of both empowerment and TQL, showing how they

are consistent with the Thomas/Tyman (1993) model of empowerment.

E. SUMMARY

This Chapter has reviewed four sources of evidence that bear on the importance of empowerment to Navy Medicine. A survey of executives in Navy Medicine showed that competencies related to empowerment were consistently seen as highly important by those executives. A survey of opinion leaders in the larger healthcare industry indicated that empowerment skills were likely to become increasingly important in the near future. An analysis of Deming's work also indicated that empowerment and intrinsic motivation are central to TQL, the management philosophy implemented within DON. Finally, available case studies show examples of empowering leadership within Navy medical treatment facilities that have proven to be highly effective. Together, this evidence consistently indicates the high importance of empowerment skills for executives in Navy Medicine.

IV. WHAT EMPOWERMENT EDUCATION IS NOW BEING DELIVERED IN NAVY MEDICINE AND ELSEWHERE?

The purpose of this Chapter is to examine what empowerment education is currently available to Navy Medicine executives. Two Navy programs currently offered are evaluated for empowerment-related content, NAVLEAD and TQL training. For contrast, a non-military healthcare executive training program is also examined for empowerment content. NAVLEAD and TQL were chosen for evaluation because they are representative of the Navy's general management education and training. The non-military healthcare program was chosen because of its recognition for excellence by the U.S. Senate.

A. NAVLEAD

NAVLEAD, formally known as Navy Leader Development Program, is taught in three categories. For the Junior Officer (defined here as O-1 to O-3) and the Chief Petty Officer (E-7 to E-9), the courses are called Basic or Advanced Division Officer NAVLEAD. The more senior officers (O-4 and above) attend the NAVLEAD Command Excellence program. Officers and Chief Petty Officers of any rank/rate can attend any course depending on where they are in their career development. The forerunner to NAVLEAD was the LMET (Leadership, Management Education and Training) set of courses

which included all ranks and rates in its training grid (Navy Leader Development Program, 1992).

Basic NAVLEAD and Command Excellence course materials were obtained from Naval Amphibious School, Coronado, California. Upon review of these materials, I found no direct reference to empowerment. There were, however, a few key concepts of empowerment being taught. The foremost empowerment concept taught in the Basic course centers around teamwork and TQL and the purpose of TQL in utilizing resources more efficiently and effectively for mission accomplishment. Overall, the five day Basic course concentrates on gaining job clarity and practicing practical applications of team building.

The five day Advanced NAVLEAD course reviews the concepts of Basic NAVLEAD and adds topics such as performance review and management control. The unit that comes closest to the empowerment model put forth in this thesis is Unit Three, which concentrates on management control. The idea of delegation is described as the behavior of assigning authority for task accomplishments to others, getting subordinates to share in task management, and encouraging others to seek task management responsibility by methods other than direct orders. The idea of intrinsic motivation is hinted at through Unit Three's "Description of the Thought," which encourages "Meeting or surpassing a personal standard of excellence." The ideas of rewards and disciplinary actions are also

discussed with the concern for positive feedback and public recognition for task accomplishments.

The two day Command Excellence seminar was developed by the management consulting firm of McBer and Company based on interviews of Navy Unrestricted Line (URL) Officers who had participated in the Senior LMET course. One of the results of this interview process was a list of eleven competencies of U.S. Navy Senior Officers. Of this list, three areas touched on the elements of empowerment and its need (Report Prepared for Navy Senior Officers - Surface, Submarine, and Air Communities, Command Excellence Seminar, NAVEDTRA 38080, 1990). These areas included positive expectation, or the direct expression to people of the belief that they can and will succeed; use of multiple influence strategies, which establishes the credibility of the leader by displaying his own expertise; and command influence, which serves to publicize an individual's or group's performance.

The Command Excellence student journal uses a short lecture followed by a coordinator-lead review of case studies based on the eleven competencies detailed in NAVEDTRA 38080. Given access only to the student journal, it cannot be clearly discerned exactly what is being taught in regards to the three competencies recognized as being related to empowerment.

Overall, we can see an increased presence in empowerment elements as the NAVLEAD training progresses from Basic Division Officer to Advanced Division Officer and through the

Command Excellence Seminar. Though not clearly spelled out as empowerment, NAVEDTRA 38080 lists eleven competencies needed of a Commanding Officer, three of which are related to empowerment.

B. NAVY TQL TRAINING

The role of empowerment in TQL was reviewed in Chapter III. Here, we will review the Department of the Navy TQL Course Catalog. This Catalog lists all TQL training currently available and gives a course description with the intent of exposing what empowerment training is being delivered.

The Senior Leaders Seminar (SLS) is the first course in the DONTQL curriculum to be taken by senior leaders. Senior leaders are described as commanding officers, executive officers, officers in charge (O-5 and above), and equivalent civilians (GS/GM-14 and above). SLS covers the basic philosophy, principles, and methods of TQL. The applicability of the course to the EME program empowerment training module should be considered minimal in that no new aspects of empowerment will be exposed.

The next course a senior leader would take is "Fundamentals of TQL." In this course, Dr. Deming's system of profound knowledge is taught in detail. It is organized around the four elements of systems theory, statistical theory, theory of psychology, and theory of knowledge. The element of importance for this discussion is the theory of

psychology, where understanding people to maximize their performance is examined. This course is not limited to senior leaders. Where it poses a problem to executives in Navy Medicine is that it only touches on the idea of empowerment and it requires 14 days away from regular duties.

The remaining courses described in the book are either intended for TQL coordinators and quality advisors or are geared towards process identification and improvement. While the Deming philosophy does, in the more basic TQL courses, display some elements of empowerment, the concept of empowerment and its potential are never brought clearly to the forefront. The more advanced TQL courses concentrate on quantitative application of Deming's theory of profound knowledge. Empowerment as the idea of intrinsic task motivation of workers is not discussed in the formal DON TQL training.

C. A NON-MILITARY PROGRAM

The Sentara Health System, a not-for-profit full service healthcare delivery organization located in Southeastern Virginia, was chosen for review for two reasons. The first is because of their status as the United States Senate Productivity Award winner in the Health Systems category, as well as winner of the 1992 USA Today/Rochester Institute of Technology Quality Cup Competition. Second, they have several

retired or former military doctors and healthcare administrators in their upper and middle management levels.

The vehicle of Sentara's success is the Continuous Quality Improvement (CQI) program which received their total organizational commitment in 1990 (Sentara Health Systems Private Sector Service, 1993). Direct cost savings from CQI results exceeded \$3 million dollars for fiscal year 1992 (Sentara Health Systems Private Sector Service, 1993).

CQI is very similar to the U.S. Navy's TQL program with the exception of one major point. The Sentara program specifically mentions empowerment as part of the third of five major components of their leadership philosophy. The first of the components is strong customer focus. The second requires senior management leadership in participation and implementation of CQI training. The fourth requires decisions to be based on fact, while the fifth refers to the need for a results-oriented mindset. The third component, the one of most interest for the purpose of this thesis, speaks of a commitment to training, empowerment, and involvement.

Further review of the Sentara CQI training materials indicates that their view of empowerment is based primarily on the idea of delegation of authority. This is evidenced in part d. of the third component:

d. All teams are empowered to make recommendations. Most teams are made up of managers and employees working together on the process, and the team is empowered to make decisions within the scope of their responsibility/

guidelines/constraints (Sentara Health Systems Private Sector Service, 1993).

Sentara also makes reference to the importance of intrinsic rewards.

In many cases, teams gain all the recognition/reward they need by experiencing directly, or indirectly, through customer feedback, the improvements in their processes (Sentara Health Systems Private Sector Service, 1993).

They stress intrinsic motivation because they recognize it as being superior to the use of an extrinsic motivator such as profit sharing. In addition, their status as a non-profit organization severely restricts their ability to formally share the cost savings gain of CQI through a profit sharing mechanism. Also supporting Sentara's view of the need for intrinsic motivation is their position that gains within the organization are "indirectly shared by all as we continue to improve our status in the community" (Sentara Health Systems Private Sector Service, 1993).

In order to gain further information regarding Sentara's views on empowerment, a telephone interview was conducted with Don Deliz, Director of Ambulatory Care Services, and a retired Navy Medical Service Corps Healthcare Administrator. Mr. Deliz views CQI and empowerment as being inseparable. He believes that one could not be successful without the other. When asked to explain what he meant, Mr. Deliz gave an example of how he empowers his staff. He related that his clinic personnel have the authority to adjudicate a disputed bill on the spot, right down to dismissal of charges. He also related

that he encourages his staff to take risks because innovation cannot occur if calculated risks are not attempted. A major part of empowerment, as he sees it, is that the employees should feel comfortable in taking honest risks and making suggestions without fear of reprisal. Mr. Deliz supported this statement by saying,

I don't know of any successful executive who hasn't made a major mistake. Taking risks are necessary if innovation is to occur. Mistakes will happen when taking these risks so retribution shouldn't occur or the innovation will stop (Deliz Interview, 1993).

D. CONCLUSIONS

There is no explicit mention of empowerment in Navy programs. A few elements are mentioned, but are not tied together into any comprehensive model. Sentara, on the other hand, makes explicit mention of empowerment and some elements of it, including intrinsic motivation. However, the elements are still not tied together into a comprehensive model. Thus, these programs appear severely limited by comparison with what could be taught.

V. IS THERE A GAP IN EMPOWERMENT EDUCATION IN NAVY MEDICINE?

In Chapter III, the importance of empowerment was established, while in Chapter IV, existing training programs were reviewed to see what, if any, empowerment training is being offered. In this Chapter, we will determine if there is a gap between what is required and what is offered in the area of empowerment education. This issue will be addressed using three sets of evidence: (1) more data from the NPS/BUMED Survey described earlier; (2) interviews conducted by the author at Naval Regional Medical Center San Diego; and (3) a comparison of the content of existing Navy training with the model of empowerment presented in Chapter II.

A. NPS/BUMED SURVEY

Recall from Chapter III that the NPS/BUMED survey asked respondents to rate, not only the importance of various competencies, but also their current skill level on those competencies. Table 4 shows the distribution of responses on both of these questions for each of the empowerment-related competencies defined in Chapter III.

As shown in Table 4, Question 35 shows 89% of respondents view empowerment skills as high in importance for CO/XOs, while a lower percentage (74%), see themselves as high in this

skill. This difference indicates recognition of a gap, or education need, in empowerment by these Navy Medicine executives.

There is a similar gap in each of the remaining empowerment-related competencies. Since survey respondents recognized that they did not possess the needed level of skill/competency associated with the concept of empowerment, this result provides another clear indication of the need for empowerment education. Appendix A contains a further breakdown of these results by respondents' position, rank, and Corps affiliation.

TABLE 4. RESPONDENTS' PERCEPTION OF
IMPORTANCE AND CURRENT SKILL LEVELS FOR
EMPOWERMENT-RELATED COMPETENCIES

QUESTION NUMBER	SKILL AREA/COMPETENCY	PERCEPTION	LOW	MEDIUM	HIGH
14	Participation	Required Current	2 1	14 27	84 72
34	Vision	Required Current	2 3	12 35	86 62
35	Empowerment	Required Current	1 2	10 24	89 74
37	Trust	Required Current	0 0	7 17	93 83
38	Managing Change	Required Current	0 1	6 24	94 75
39	Conflict Resolution	Required Current	0 1	8 30	92 69
40	Teamwork	Required Current	1 1	6 23	93 76
41	Culture	Required Current	1 1	5 23	94 76
42	Motivation	Required Current	1 0	5 25	94 75
44	Subordinates	Required Current	1 1	9 24	90 75
46	Innovation	Required Current	1 1	14 32	85 76
54	Feedback	Required Current	1 1	6 25	93 74
59	Open Communications	Required Current	0 1	5 17	95 82

By viewing this data on the 13 empowerment-related questions, we can clearly see that a significant number of executives in Navy Medicine feel that their current

empowerment-related skills do not meet the level of skill perceived as required for executives at the respondents' level in the organization.

B. INTERVIEWS AT NAVAL REGIONAL MEDICAL CENTER SAN DIEGO

On September 9 and 10, 1993, interviews were conducted with two Department Heads, four Assistant Directors, and two Directors at Naval Regional Medical Center San Diego. The intent of the interviews was to determine what empowerment education, if any, these Naval Medical executives have had. Also, the interviews were intended to help establish the roles of these leaders in empowering their staff (to be discussed in Chapter VI). The San Diego site was chosen because of its reputation for rapid progression in the implementation of Total Quality Leadership. All Department Heads and Assistant Directors were Commanders or Captains, while both Directors interviewed were Captains.

Each officer interviewed was asked about any education they might have had in empowerment and what empowerment education they thought was needed. All interviewees cited no formal education in empowerment but felt that the basic TQL classes they attended had some elements of empowerment. All respondents felt that the empowerment training needs of Department Heads, Directors, and Commanding Officers were not being met.

The interviews conducted at Naval Regional Medical Center San Diego reveal that the executives interviewed know the motivational effects of extrinsic task motivation (i.e., rewards and punishments) and all levels view empowerment as being a potentially valuable tool. However, none of the persons interviewed understood empowerment as based in intrinsic motivation. The concept of empowerment interventions, extrinsic task motivation, and most importantly, intrinsic task motivation should be taught to all levels of Naval Medicine executives.

It should be noted further that the interviewees stated that Navy Medicine was very persistent in trying to obtain training quotas in the LMET program. However, according to CDR Stoessel, NC, USN, Department Head of Staff Education and Training at Naval Regional Medical Center San Diego, very few Navy Medical Department personnel have attended NAVLEAD because of the unavailability of quotas. This limited exposure has resulted in very little interest on the part of Officers in the medical community. CDR Stoessel also indicated that NAVLEAD is being redesigned to directly include elements of TQL in the teaching and training format.

C. EXAMINATION OF CONTENT OF COURSES

The review of existing major training programs in Chapter IV revealed that these programs, both private sector and Navy taught, provide some pieces of empowerment-related knowledge,

but don't provide a comprehensive understanding of empowerment and how these pieces fit together.

A major shortcoming in existing programs is their failure to identify a motivational foundation for empowerment. Each of these programs also fails to consider a comprehensive set of building blocks or interventions that is necessary to create empowerment. In addition, the programs reviewed did not include the elements of empowerment (choice, competence, meaningfulness, and progress) which identify the feelings of the worker.

D. SUMMARY

All three sets of evidence lead to the conclusion that there is a significant gap in empowerment education for Navy Medicine executives.

VI. SUMMARY AND RECOMMENDATIONS

A. SUMMARY

This thesis has examined the need for empowerment training in Navy Medicine's EME Program and what content should be offered.

Chapter II provided an overview of empowerment, focusing on both its motivational content (intrinsic motivation) and the variety of interventions that produce it. This Chapter was based largely on the work of Thomas and Tymon (1993), which highlights the key role of four elements of empowerment - choice, competence, meaningfulness, and progress.

The need for empowerment education in Navy Medicine was established in Chapter III. The NPS/BUMED survey provided input directly from the source, i.e., executives in Navy Medicine, demonstrating the importance of empowerment competencies. The Healthcare Forum Survey stressed the need for a shift to empowerment in order to succeed in the 1990's and into the next century. Also in Chapter III, we saw the positive results that Navy medical treatment facilities can realize under empowering leadership.

In Chapter IV, a review of existing major training programs such as NAVLEAD and TQL training was conducted in order to determine what empowerment-related competencies are

presently being taught. Also reviewed was the Sentara Healthcare System's award-winning CQI program which specifically addresses empowerment and views it as an integral part of their very successful CQI program. While all of these programs teach some empowerment-related competencies, there is no comprehensive, integrated treatment of the topic which includes the material laid out in Chapter II.

Chapter V concluded that there was in fact a gap in empowerment education. This conclusion was based on NPS/BUMED survey data, supplemented by interviews with executives at a Naval Regional Medical Center and further examination of the content of current training.

B. RECOMMENDATIONS

This thesis has exposed the need for and desire for empowerment training for executives in Navy Medicine. It has established that this need is not presently being met. This thesis has also shown the financial benefits experienced by both a Naval Hospital whose leader was a very strong proponent of empowerment and a private sector healthcare system. In this day and age of dwindling resources and increasingly complex delivery systems, the implementation of empowerment techniques is essential to meet the continued need for medical services within the Navy.

Empowerment education for EME program based on the general lines of the Thomas and Tymon Model is recommended. It should

be taught as a "driver" for a more rapid and thorough implementation of the Total Quality Leadership Program. It is also recommended that further research be conducted to determine how to best merge empowerment training into the Navy's TQL program with the intent of making it more understandable and more rapidly implementable. The economic and quality of life value of empowerment has been demonstrated and it is obvious that management will have to accomplish more with less resources. Research in the field of leadership has shown that it is possible to energize workers. For these reasons, it seems essential that the EME program include a module on empowerment using the four elements of choice, competence, meaningfulness, and progress as presented in the Thomas and Tymon model.

APPENDIX A

NPS/BUMED SURVEY RESULT BREAKDOWN BY RESPONDENT'S POSITION, RANK, AND CORPS AFFILIATION

This Appendix provides further breakdown of the NPS/BUMED Survey discussed in Chapters III and IV. Please note that although there are some differences among categories of respondents, the patterns remain remarkably similar, indicating significant gaps within all categories of respondents below the rank of Admiral. The responses were further broken down into the categories of Commanding Officer with less than 12 months in the current position, Commanding Officer with more than 12 months in the current position, Executive Officer with less than 12 months in the current position, Executive Officer with greater than 12 months in the current position, Director, and Department Head.

PERCENT OF RESPONDENTS RATING COMPETENCIES AS HIGHLY IMPORTANT (REQUIRED), BROKEN DOWN BY CURRENT POSITION

QUESTION NUMBER	CO<12	CO>12	XO<12	XO>12	DEPT. HEAD	DIRECTOR
14	87.50	85.71	87.88	81.58	90.91	84.14
34	91.67	93.88	84.85	89.47	77.27	85.00
35	91.67	89.80	87.88	92.11	84.09	87.86
37	95.83	95.92	96.97	94.74	95.45	91.43
38	93.75	95.92	96.97	94.74	95.45	92.14
39	91.67	91.84	96.97	94.74	93.18	92.14
40	91.67	93.88	96.97	97.37	95.45	92.86
41	95.83	97.96	96.97	94.74	93.18	93.57
42	93.75	91.84	96.97	97.37	95.45	95.00
44	89.58	89.80	90.91	92.14	90.91	94.74
46	91.67	81.63	90.91	89.47	84.09	84.89
54	91.67	97.96	96.97	94.74	88.64	94.29
59	93.75	93.88	96.97	95.74	93.18	95.71

The current skills possessed by the Navy healthcare executives, broken out by question and position, are as follows:

**PERCENT OF RESPONDENTS RATING THEMSELVES
AS CURRENTLY HIGH IN COMPETENCIES, BY POSITION**

QUESTION NUMBER	CO<12	CO>12	X0<12	X0>12	DEPT. HEAD	DIRECTOR
14	75.00	75.51	69.70	84.21	65.91	71.94
34	72.92	75.51	48.48	76.32	61.36	57.86
35	77.08	79.59	69.70	86.84	68.18	69.29
37	83.33	87.76	81.82	89.47	88.64	77.14
38	79.17	75.51	60.61	84.21	81.82	75.00
39	68.75	65.31	63.64	78.95	68.18	69.29
40	75.00	83.67	72.73	86.84	84.09	71.22
41	77.08	81.63	66.67	84.21	79.55	72.86
42	72.92	73.47	66.67	84.21	77.27	73.57
44	75.00	75.51	69.70	84.21	77.27	76.43
46	70.83	75.51	60.61	73.68	56.82	66.19
54	70.83	75.51	69.70	78.95	68.18	75.00
59	83.33	85.71	72.73	89.47	81.82	82.86

By comparing the percents for each question and category of executive, a definite trend appears. For example, if one compares Question 14, category of CO<12 months, on the Required Skills chart with the same spot on the Current Skills chart, there is a gap between what is required and what skills are currently possessed. For every question in every executive category there is a similar gap between what is required and the current skills possessed.

Comparing the data for the 13 empowerment related questions when broken out by rank of respondent reveals a similar pattern. The required skills, broken out by question and rank of respondent, is as follows:

**PERCENT OF RESPONDENTS RATING COMPETENCIES
AS HIGHLY IMPORTANT (REQUIRED), BY RANK**

QUESTION NUMBER	ADM	CAPT	CDR	LCDR	OTHER RANKS
14	100.00	85.90	86.46	83.72	72.73
34	100.00	85.26	88.54	83.72	81.82
35	100.00	90.06	87.50	83.72	72.73
37	100.00	95.19	93.75	90.70	72.73
38	100.00	94.23	94.79	90.70	81.82
39	100.00	92.31	92.71	90.70	81.82
40	100.00	94.23	95.83	90.70	81.82
41	100.00	96.15	91.67	95.35	90.91
42	100.00	94.55	94.79	95.35	81.82
44	100.00	89.42	92.71	90.70	81.82
46	100.00	85.85	87.50	83.72	45.45
54	100.00	93.27	93.75	95.35	90.91
59	100.00	94.23	96.88	95.35	81.82

The current skills possessed by Navy healthcare executives, broken out by question and rank of respondent, is as follows:

**PERCENT OF RESPONDENTS RATING THEMSELVES
AS CURRENTLY HIGH IN COMPETENCIES, BY RANK**

QUESTION NUMBER	ADM	CAPT	CDR	LCDR	OTHER RANKS
14	100.00	73.95	66.67	77.27	63.64
34	100.00	63.99	60.42	54.55	36.36
35	100.00	77.17	65.63	70.45	54.55
37	100.00	83.60	81.05	88.64	54.55
38	100.00	73.95	70.83	90.91	45.45
39	90.00	69.13	62.50	81.82	45.45
40	100.00	80.32	67.71	75.00	54.55
41	100.00	78.78	69.79	79.55	63.64
42	100.00	77.49	66.67	77.27	63.64
44	100.00	75.88	72.92	79.55	63.64
46	100.00	70.00	60.42	63.64	45.45
54	100.00	74.28	71.88	79.55	63.64
59	100.00	82.32	84.38	77.27	81.82

When comparing the skills required with the skills currently possessed, we once again can see that all ranks of executives show significant gaps between their current

abilities and what is required. The one exception involves Admirals, who indicate that their current skills almost exactly match what is required of their position. The rank that stands out as having the greatest gap between current and required skills is that of Commander (CDR).

A final breakout was done by Corps. Navy Medicine is divided into specialty groups or corps of commissioned officers based on occupational expertise. The Medical Corps (MC) consists of doctors holding a degree of Medical Doctor or Doctor of Osteopathy. The Nurse Corps (NC) consists principally of registered nurses with BSN degrees. The Dental Corps (DC) consists of personnel possessing Doctor of Dentistry degrees, including oral surgeons. The Medical Service Corps is subdivided into two groups. The first is the Allied Health Science Officers (AH) who are involved in direct patient contact such as optometrists and pharmacists - the clinical sciences. The second is Health Care Administrators (HCA). Again, there was a similar gap in what skill is required and skill currently possessed. The data is as follows:

**PERCENT OF RESPONDENTS RATING COMPETENCIES
AS HIGHLY IMPORTANT (REQUIRED), BY CORPS**

QUESTION NUMBER	MSC-AH	DC	MSC-HCA	MC	NC
14	86.21	82.47	87.10	84.31	98.00
34	96.55	83.51	89.25	83.12	94.00
35	89.66	85.57	88.17	88.31	100.00
37	93.10	92.78	95.70	93.51	100.00
38	96.55	89.69	95.70	94.16	100.00
39	100.00	87.63	92.47	92.86	100.00
40	93.10	93.81	96.77	92.86	100.00
41	96.55	93.81	95.70	94.16	100.00
42	96.55	92.78	93.55	96.10	100.00
44	96.55	88.66	93.55	90.91	92.00
46	86.21	81.44	92.47	81.05	98.00
54	96.55	90.72	96.77	92.86	96.00
59	96.55	90.72	97.85	94.16	100.00

The current skill possessed by Navy healthcare executives, broken out by question and Corps affiliation, is as follows:

**PERCENT OF RESPONDENTS RATING THEMSELVES
AS CURRENTLY HIGH IN COMPETENCIES, BY CORPS**

QUESTION NUMBER	MSC-AH	DC	MSC-HCA	MC	NC
14	76.67	65.98	89.25	67.11	72.00
34	66.67	58.76	75.27	57.52	66.00
35	80.00	72.16	77.42	70.59	80.00
37	79.31	80.41	89.25	82.35	84.00
38	80.00	68.04	81.72	74.51	74.00
39	73.33	64.95	72.04	66.67	70.00
40	86.21	69.07	86.02	73.86	80.00
41	76.67	74.23	86.02	71.90	84.00
42	80.00	72.16	82.80	73.20	76.00
44	80.00	71.13	84.95	68.63	88.00
46	63.33	64.95	79.57	61.18	66.00
54	80.00	73.20	79.57	66.67	86.00
59	83.33	77.32	84.95	81.05	88.00

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